Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

MEDICAL EQUIPMENT DEVICE
SPECIALISTS
7050 DUNBROOK RD.
SAN DIEGO, CA 92126

Respondent Name:
LM INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number:
M4-11-4151-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual has failed to respond as to why every patient falls under xe20, and failed to identify which of the three denial reasons was the applicable one for each respective patient that was denied."

Amount in Dispute: $2,005.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Medical bills are required by TDI to be submitted with 95 days. At the time we received this Medical Dispute we had not previously received the bills for services on 6/17/10 or 7/17/10. Therefore the bills for these two dates of service were not timely filed.

Response Submitted by: Liberty Mutual Ins. Co., 2875 Browns Bridge Rd., Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2009 through June 17, 2010	HCPCS Codes E1399, A4595, E0731	$1,933.83	$0.00
July 17, 2010	HCPCS Code A4595	$72.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits were not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request." Review of the *Table of Disputed Services* shows that dates of service October 12, 2009 through June 17, 2010 were not filed no later than one year after the date(s) of service in dispute with in accordance with 28 Texas Administrative Code §133.307(c)(1)(A)." Therefore, these dates of service will not be considered in this review.
2. The respondent states in their position summary that the requestor had not previously received the bills for services on 6/17/10 or 7/17/10. Review of the medical bill submitted by the requestor shows a date of July 30, 2010; however, the requestor submitted no information to support the initial medical bill had been sent to the carrier in accordance with Texas Administrative Code 133.20(b).
3. Pursuant to 28 Texas Administrative Code §133.307(c)(2)(A-B) the request for medical fee dispute resolution shall include a copy of all medical bills, in a paper billing format, as originally submitted to the carrier and a copy of all medical bills submitted to the carrier for reconsideration in accordance with §133.250 of this chapter relating to reconsideration for payment of medical bills. The documentation submitted by the requestor does not support that the respondent received a copy of the initial medical bill nor does the reconsideration/appeal cover sheet support that a request for reconsideration was made or was received by the respondent.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 9, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).